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84-1038

No. ———

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

MARIO DE MODENA, dba SIXTH AVENUE PHARMACY, *et al.*,
Petitioners,

v.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,
Respondents.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,
Petitioner,

v.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTION PRESENTED

Are purchases of drugs by subscription health care organizations purchases "by charitable institutions" of "supplies for their own use" and thereby exempt from the Robinson-Patman Act under the Nonprofit Institutions Act, even though the drugs are resold for home use in direct competition with neighborhood retail pharmacies?

LIST OF PARTIES

Parties to the proceeding in the United States Court of Appeals for the Ninth Circuit were as follows:

Mario DeModena, dba Sixth Avenue Pharmacy; Hillcrest North Pharmacy, De Anza View Enterprises, and The Apothecary Shop, Edwin Drucker, dba Mission Park Pharmacy; Robert W. Born, dba MacLay Drug Company; Wellington, Inc., a corporation; Jewell Pharmacy, Inc., a corporation; Eugene Elkin, dba Kustner's Medical Square Pharmacy, and WVP Corporation, plaintiffs in No. 83-5720.

Kaiser Foundation Health Plan, Inc., a California corporation; Kaiser Foundation Hospitals, a California corporation; Kaiser Foundation Health Plan, Inc., a Washington corporation; Kaiser Foundation International, Permanente Services, Inc., Southern Permanente Services, Inc., Permanente Services of Hawaii, Inc., The Permanente Medical Clinic, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan of Colorado, Inc., Colorado Permanente Medical Group, P.C., Kaiser Community Health Foundation, Ohio Permanente Services, Inc., and Ohio Permanente Medical Group, defendants in No. 83-5720.

Portland Retail Druggists Association, Inc., an Oregon nonprofit corporation, plaintiff in No. 83-5721.

Kaiser Foundation Health Plan, Inc., a California corporation; Kaiser Foundation Hospitals, a California corporation; Kaiser Foundation Health Plan of Oregon, a Washington corporation, and Permanente Services of Oregon, a California corporation, defendants in No. 83-5721.

The Medical Group and Permanente corporations are for-profit organizations.

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Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Plaintiff retail pharmacies petition for a writ of certiorari to review a decision of the United States Court of Appeals for the Ninth Circuit.

OPINION BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit is reported at 743 F.2d 1388, and a copy is reprinted as Appendix A to this petition.

JURISDICTION

The decision of the court of appeals was filed on October 2, 1984. Issuance of that court's mandate has been stayed pending resolution of this petition. Jurisdiction of this Court is based on 28 U.S.C. § 1254(1).

STATUTORY PROVISION

The Nonprofit Institutions Act, 15 U.S.C. § 13c, provides:

> That nothing in the [Robinson-Patman Act] shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit.

STATEMENT OF THE CASE

The De Modena petitioners, owners and operators of retail pharmacies in California, and petitioner Portland Retail Druggists Association, Inc., an Oregon nonprofit corporation representing 67 retail pharmacies in or near Portland, Oregon, brought separate class actions against various of the respondents in the U.S. District Courts for the Central and Northern Districts of California under the Sherman and Clayton Acts (on which jurisdiction was based), alleging, among other things, that,

> (i) in violation of Section 2 of the Clayton Act, as amended by the Robinson-Patman Act, respondents were knowingly receiving discriminatorily low prices on purchases of over-the-counter and prescription drugs;
>
> (ii) such price discrimination was not justified by differences in cost of manufacture, sale or delivery resulting from differing methods or quantities of respondents' purchases; and
>
> (iii) respondents, with others, had acted to conceal such price discrimination.

These two cases were consolidated for trial on the Central District of California. Prior to a hearing on the merits, the district court granted a motion to dismiss by the respondents, but was reversed by the Court of Appeals for the Ninth Circuit. 662 F.2d 641, reprinted as Appendix B to this petition. Following remand, the district court granted summary judgment for respondents, and the court of appeals affirmed, on the ground that respondents' drug purchases are exempt from the Robinson-Patman amendment of the Clayton Act by reason of the Nonprofit Institutions Act.

Respondents (listed on p. ii above), are a complex of interrelated organizations which provide prepaid medical and dental care, drugs and other products in nine states, including Oregon, California, and Washington. They constitute the largset single non-public purchaser of prescription drugs, and one of the largest non-public purchasers of over-the-counter drugs, in the United States. In 1977, the year petitioners filed their complaints, respondents' health plan in Oregon alone had 210,000 subscribers or 18% of the general population.[1] Of these subscribers 35% were also subscribers to respondents' drug plan.

Respondents operate pharmacies at hospitals and outlying clinics for the sale to the general public of over-the-counter and prescription drugs, as well as a variety of health-related consumer products usually sold in drug stores. During most of the period covered by the complaint these pharmacies were operated by Permanente Services of Oregon (in Oregon) and Permanente Services, Inc. (in California), both of which were for-profit corporations owned equally by Kaiser Foundation Health

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[1] In Northern California, comparable figures were 1,417,000 subscribers constituting 24% of the general population. Under the coverage of many subscribers, additional family members are included.

Plan, Inc. and Kaiser Foundation Hospitals. Because of the discriminatory prices received by respondents (including the Permanente Clinics, partnerships of physicians in private practice for profit), they are able to offer drugs to the non-hospitalized at prices substantially below those paid by competing neighborhood pharmacies, with a resulting loss to the public of many such pharmacies.

DECISION OF THE COURT BELOW

The court of appeals equated the retail pharmacy operations of respondents to charitable institutions, such as schools, colleges, universities, public libraries, churches, and hospitals. The court concluded (erroneously, we would submit) that, since some of the respondents are non-profit organizations, and that organizations which "promote health" are considered charitable under the law of trusts and are exempt from income taxes as charitable institutions, all of the respondents are "charitable institutions," as the term is used in the Non-profit Institutions Act. The court of appeals held that drug purchases of the respondents are purchases by a "charitable institution." The court further held that such purchases are "purchases of their supplies" for "their own use," as these terms are used in the exempting statute, even though the drugs are resold to the general public. The court dismissed petitioners' actions as to all respondents, except as to "sales of drugs to non-members." [2] The court of appeals would treat all members of the general public as "members" if they have subscribed to a medical or health plan even though they have not subscribed to an optional drug plan.

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[2] As to these sales, the court of appeals would remand for determination whether such sales are "a de minimis violation." Appendix, page 15a, below.

REASONS FOR GRANTING THE WRIT

1. The case presents an important question of federal law because the answer will preserve or destroy nationwide competition in the supply of drugs for home use.

Whether mass purchases by respondents of drugs which are resold to individual purchasers for home use are "purchases of their supplies for their own use" by respondents is an important question because of the need to preserve competition between alternate methods of health care supply in the United States, that between the fee-for-service method of health care, (in which a consumer pays a separate charge for each medical service or drug), and the subscription method, in which the consumer transfers some of the risk to the contractual health plan corporation by paying a fixed monthly charge in return for which services and drugs are provided as needed. This competition, especially that of neighborhood retail pharmacies, gives the consumer a variety of alternative sources of medicines at convenient locations and hours of service.

The decision of the court below, concluding that purchases of drugs by the respondents at discriminatory prices are purchases of their supplies for their own use even though resold for home use, does not leave to a free market the competition between pay-as-you-go drug purchase and contractual pre-payment plans. Rather, it makes a policy decision destructive to further competition between the competing methods, since it exempts the prepayment method from the federal prohibition against inducement or knowing receipt of discrimination not justified by cost savings and would deprive the public of the continuing benefits of such competition, including the convenience of neighborhood pharmacies. As alleged in the Portland Association's summarily dismissed complaint, the price discrimination (and its inducement) exempted by the decision of the court below from the prohibitions of the Clayton Act has "resulted in the failure of numer-

ous retail or community pharmacies in the states of California, Oregon and Washington" and, if the discrimination continues, it "will result in the failure of an additional and substantial number" of such pharmacies in those states.

The decision below also favors the subscription method over nonprofit hospitals, even including governmental hospitals, since the latter are subject to the limitations of *Abbott Laboratories v. Portland Retail Druggists Ass'n.*, 425 U.S. 1 (1976), reprinted as Appendix C to this petition, page 30a. In that case this Court held that drug purchases of hospitals used to refill prescriptions, to supply hospital medical staff for resale in private practice, or for sales to customers not being treated at the hospital are not "purchases of their supplies for their own use."

2. This question has not been settled by this Court.

Whether purchases of drugs by a subscription health scheme, not itself organized for profit but affiliated with individuals and organizations acting for their own profit, should be regarded as "purchases of their supplies for their own use" by a "charitable institution" even when the drugs are resold at the same functional level as neighborhood pharmacies to a broad spectrum of the general public, has not been settled by this Court. There is an obvious need for a definitive construction of these terms in the Nonprofit Institutions Act. As the court below acknowledged, there is "little law" in this area, and "the only relevant case" is the *Abbott* case. (See p. 7a of Appendix A.) That case dealt with purchases of drugs by nonprofit hospitals and held that some such purchases are "purchases of their supplies for their own use" and some are not, depending on how the drugs are used. The case did not involve subscription health plans or their purchases of drugs for resale.

3. The decision of the court below is in conflict with the only relevant decision of this Court, which limited the exemption to exclude resales in competition with neighborhood pharmacies.

In the *Abbott* case, the Court found "nothing in the [Nonprofit Institutions] Act that indicates that its exemption provision is to be applied and expanded automatically to whatever new venture the non-profit hospital finds attractive in these changing days. The Congress surely did not intend to give the hospital a blank check." 425 U.S. at 13. The Court distinguished ten different categories of use, declaring some for the hospital's "own use" and some "on the other side of the line that divides that which is in the hospital's 'own use' from that which is not." 425 U.S. at 15. The decision of the court below in this case would permit any hospital to step over this "line," as the respondents did here, by forming a subscription organization to buy the drugs, and it would handicap any competing hospital (charitable, nonprofit or otherwise), which failed to do so, since such hospital remains subject to the restrictions of the *Abbott* decision. The decision of the court below conflicts with this Court's opinion in the *Abbott* case and with the national health policy that competition and consumer choice are to be favored. *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 392 (1981). See, also, *Jefferson County Pharmaceutical Ass'n., Inc. v. Abbott Laboratories*, 460 U.S. 150 (1983).

Although this Court's decision in the *Abbott* case did not settle the question presented by this case, it pointed in another direction from that selected by the court below, which would exempt all purchases of drugs by pre-paid subscription corporations resold to the corporation's subscribers, (even if they do not subscribe to the corporation's drug plan), regardless of where, when, or what use is made of the drugs or of the competitive con-

text in which such resale takes place. In declining in the *Abbott* case to exempt purchases of hospitals used to refill prescriptions, to supply hospital medical staff for resale in private practice, or for sales to customers not being treated at the hospital, this Court concluded that the exemption provision of the Nonprofit Institutions Act is "a limited one" (425 U.S. at 14), and emphatically refused to deprive of all meaning the phrase "purchases of their supplies for their own use," as the court below has done in this case.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Nos. 83-5720, 83-5721
DC No. CV 77-5-IH

MARIO DE MODENA, dba SIXTH AVENUE PHARMACY, *et al.*,
Plaintiffs-Appellants,
v.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,
Defendants-Appellees.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC.,
Plaintiff-Appellant,
v.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,
Defendants-Appellees.

[Filed Oct. 2, 1984]

On Appeal from the U.S. District Court
for the Central District of California
Hon. Irving Hill, Senior U.S. District Judge, Presiding

Argued and Submitted November 7, 1983

Before: BROWNING and NORRIS, Circuit Judges, and KING, District Judge.*

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* Honorable Samuel P. King, Chief U.S. District Judge for the District of Hawaii, sitting by designation.

OPINION

NORRIS, Circuit Judge:

I. FACTS

Appellants are retail pharmacies located in Oregon and California. Appellees are the related corporations—including regional health plans, regional medical groups, and non-profit hospitals—that make up the Kaiser-Permanente Medical Care Program.

Appellees provide health care in a manner substantially different from the traditional fee-for-service method of health care in which a consumer pays a separate charge for each medical service or good provided by the doctor or hospital. The regional Kaiser Health Plan (HP's) contract with consumers who wish to become members and provide them with medical care in return for monthly dues. Each HP provides this care through two related organizations: Kaiser Foundation Hospitals, a California non-profit corporation which operates the Kaiser hospitals, and one of the eight regional Permanente Medical Groups. In addition, the HP's provide intersted members with a "drug plan." Under this plan, for an additional monthly charge, members obtain the right to purchase drugs at little or no cost. They can purchase these pharmaceuticals at a Kaiser hospital or at a pharmacy at a non-hospital location operated by an HP.[1]

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[1] Before 1977, the Kaiser appellees were organized in a slightly different manner. The pharmacies located outside of the hospitals were not operated by the regional HP's but by regional Permanente Service Corporations. These nonprofit corporations were formed because the Internal Revenue Service stated that the regional health plans would not be considered charitable organizations under the Internal Revenue Code if they ran the pharmacies. The Permanente Service Corporations, however, returned all receipts to the HP's less costs and a rate of return on capital. The Service

In this antitrust action, appellants advance three discrete claims concerning appellee's provision of drugs to HP members. First, they argue that appellees violated the Robinson-Patman Act, 15 U.S.C. § 13, by buying drugs at discriminatorily low prices from pharmaceutical companies and dispensing these drugs to HP members. Second, appellants maintain that appellees are attempting to monopolize the retail drug market in violation of section 2 of the Sherman Act, 15 U.S.C. § 2. Third, they contend that appellants violated section 3 of the Clayton Act, 15 U.S.C. § 3, by tying the sale of drugs to the sale of other health services.

Appellees moved for summary judgment below, and the district court granted the motion on all three claims.[2] Appellants then brought this timely appeal).

Corporations paid taxes on the amount allocated for rate of return on capital and then paid the amount remaining to the HP's.

In 1977, the Internal Revenue Service declared that its denial of charitable status to health plans which operated pharmacies was erroneous. The Service Corporations were then disbanded and control of their pharmacies transferred directly to the HP's.

Because the Internal Revenue Service stated that the Service Corporations should have been treated as charities for purposes of the Internal Revenue Code and because the Service Corporations engaged only in activities that the HP's currently engage in, we believe the analysis under the Robinson-Patman Act for sales by the Service Corporations is the same as that for sales by the HP's. Consequently, we will treat all sales at pharmacies located outside Kaiser hospitals as being sales made by the HP's even if some of those sales occurred before 1977 and were thus actually made by Service Corporations.

[2] Actually, the summary judgment before us is the second one granted by the district court in this case. We reversed the first one—granted in 1978—on the ground that appellants should have received additional time for discovery before the motion for summary judgment was granted. *Portland Retail Druggists Ass'n v. Kaiser Foundation Health Plan*, 662 F.2d 641 (9th Cir. 1981). On remand, the district court permitted discovery for as long as appellants requested.

II. THE ROBINSON-PATMAN ACT CLAIM

The district court ruled that appellees were not liable for violating the Robinson-Patman Act—even assuming they bought drugs at discriminatorily low prices—because they fall within an exception to that Act created by the Nonprofit Institutions Act.

The Nonprofit Institutions Act provides, "Nothing in the [Robinson-Patman Act] shall apply to purchases of *their* supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit." 15 U.S.C. § 13c. Appelles can thus qualify for this exception if they are 1) non-profit institutions; 2) eligible institutions under the Act; and 3) made the purchase in question for their "own use."

A

The HP's and Kaiser Hospitals are organized as non-profit institutions and would thus appear to meet the Act's requirements. Appellants argue, however, that these institutions are not really non-profit because they are controlled by Permanente Medical Groups, which are for-profit corporations consisting of doctors who provide medical care for members.[3]

We disagree. Both the Internal Revenue Service and the district court found that the Medical Groups do not exert control over the HP's, and given the financial arrangements between the Medical Groups and the HP's,

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[3] As already indicated, appellants assert a Robinson-Patman Act claim against all appellees, including the regional Permanente Medical Groups. The Medical Groups, however, do not sell drugs to members. Rather, they prescribe drugs which members purchase at one of the pharmacies operated by either an HP or Kaiser Hospitals. Because the Robinson-Patman Act governs only those who buy and sell at discriminatorily low prices, and not those who indirectly benefit from such purchases, *see* 15 U.S.C. § 13(a), appellants' claim against the Medical Groups must fail.

we believe that this conclusion is persuasive. The Medical Groups do not set their own fees. The HP's pay the Medical Groups an agreed upon amount per member per month, and this amount does not vary with the volume of service the group provides to the membership.[4] This fact greatly limits the amount of control the Medical Groups can exercise over the HP's. That the HP's and Kaiser Hospitals must fulfill their need for certain medical services by contracting with doctors who seek a profit does not make the HP's and Kaiser Hospitals themselves for-profit organizations.

B

We next consider whether the HP's and Kaiser Hospitals are eligible institutions under the Nonprofit Institutions Act. With respect to Kaiser Hospitals this question is easily answered. The Act explicitly lists hospitals as eligible organizations. In the case of the HP's, however, the answer is not as simple. The Act does not explicitly list HP's. Thus, we must determine whether such organizations are charitable institutions within the meaning of the Act.

There is no case law concerning which institutions are considered charitable for purposes of the Nonprofit Institutions Act. There is, however, a substantial body of precedent defining the term charitable for purposes of the tax code and the law of charitable trusts. Because the drafters of the Nonprofit Institutions Act wished to protect the same eleemosynary institutions that are given

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[4] A small portion of the payment to the Medical Groups—generally around five percent of the total payment—does not depend solely upon the number of members in the Medical Group's region. This portion is withheld by the HP and paid to the Medical Groups only if appellees meet their yearly financial goals. This system of payment is designed to give the doctors in the Medical Groups an incentive to keep costs low, and it is required by regulations promulgated pursuant to the Health Maintenance Organizations Act. 42 C.F.R. § 110.104(b)(1)(v).

special consideration under the tax and charitable trusts laws, *see* S. Rep. No. 1769, 75th Cong., 3rd Sess 1. (1938); H.R. Rep. No. 2161, 75th Cong., 3rd Sess. 1 (1938), we believe it is appropriate to refer to these precedents here. Thus, we look to this body of case law for guidance in determining whether the HP's are charitable institutions within the meaning of the Nonprofit Institutions Act.

"The definition of the term 'charitable' has never been static and has been broadened in recent years." *Eastern Kentucky Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1286 (D.C. Cir. 1974), *modified on other grounds*, 426 U.S. 26 (1976), *cited with approval, Abbott Laboratories v. Portland Retail Druggists Assn.*, 425 U.S. 1, 11 (1976) (concept of the non-profit hospital has expanded over the years). In earlier times, health organizations were recognized as charitable only if they were supported primarily by donations and used those donations to provide health care for the indigent. *Id.* With the emergence of social welfare, insurance, and municipal hospitals, however, the number of poor requiring free or below cost medical services was drastically reduced. This reduction eliminated the rationale upon which the traditional, limited definition of charitable was predicated, resulting in a move towards a less restrictive interpretation of the term in recent years. *Id.* at 1288-89. Now all non-profit organizations which promote health are considered charitable under the law of charitable trusts. *Restatement (Second) of Trusts* § 368, at 246 (1959); G. Bogert & G. Bogert, *Law of Trusts* § 62 (1973). Further, a number of courts have specifically held that health maintenance organizations, such as the HP's, are charitable institutions for tax purposes. *Sound Health Ass'n v. Commissioner*, 71 T.C. 158, 177-81 (1970). Indeed, both the HP's and Kaiser Hospitals are exempt from income taxes as charitable institutions. Given this increasingly liberal interpretation of the term, we conclude that the

HP's are charitable institutions within the meaning of the Nonprofit Institutions Act.

C

Finally, we must determine whether the purchases here in question were made for the HP's and Kaiser Hospitals' "own use." [5] Appellants contend that the HP's and Kaiser Hospitals purchased drugs not for their own use, but for the use of others, namely their members. Appellees contend, by contrast, that what they purchase for the use of their members is purchased for their "own use" within the meaning of the Act.

The "own use" issue is conceptually the most challenging aspect of this case because there is so little law in this area; the only relevant case is *Abbott Laboratories* v. *Portland Retail Druggists Ass'n*, 425 U.S. 1 (1976). In *Abbott Labs*, the Court addressed the question whether sales of drugs purchased at discriminatorily low prices by non-profit, fee-for-service hospitals—hospitals which were not part of a health maintenance organization such as Kaiser—were exempt under the Nonprofit Institutions Act.

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[5] At this point, we can treat the HP's and Kaiser Hospitals as one organization for analytical purposes because whatever is in the "own use" of one part of a health maintenance organization would be in the "own use" of another. After all, whether a member purchases his drugs from a pharmacy run by a regional HP or one run by Kaiser Hospitals doubtless depends on the fortuity of which location is more convenient for the member.

Appellants argue, in effect, that we cannot consider the interest of Kaiser Hospitals in serving members because membership is a matter between the consumer and his regional HP and because the HP's and Kaiser Hospitals are distinct corporations. Appellant's Opening Brief at 12. But appellants have misapprehended the legal relevance of corporate structure. The cases they cite merely stand for the proposition that the presence of two or more corporations acting together is sufficient to satisfy the "combination, contract, or conspiracy" requirement which triggers the substantive provisions of section 1 of the Sherman Act.

In resolving this question, the Court was torn between two competing concerns. On the one hand, the Court was interpreting an explicit exemption from the Robinson-Patman Act that reflected Congress' desire to aid non-profit institutions even when those institutions fulfilled needs beyond those traditionally fulfilled by charities. *Id.* at 13. On the other hand, the Court reiterated the maxim that exceptions to the Robinson-Patman Act are to be construed narrowly and emphasized that this exemption in particular was not "to be applied and expanded automatically to whatever new venture the non-profit hospital finds attractive in these changing days." *Id.*

The Court resolved this tension by formulating a test which it found "inherent in the language of the statute." *Id.* at 14. Under this test, " 'their own use' is what reasonably may be regarded as use *by the hopsital* in the sense that such use is a part of and promotes the hospital's intended institutional operation in the care of persons who are its patients." *Id.* (emphasis in the original).

The Court applied this test to ten separate categories of drug sales. The Court exempted sales of drugs to in-patients, emergency room patients, and out-patients for use on hospital premises. The Court also exempted sales to both in-patients and out-patients for take home use, sales to hospital employees and students for their personal use or use by their dependents, and sales to the hospital's medical staff for their personal use or use by their dependents. The Court declined to exempt sales on prescription refills, sales to the hospital's medical staff for resale in private practice, and sales to walk-in customers who were not being treated at the hospital.[6]

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[6] The language of the Nonprofit Institutions Act speaks only to purchases by institutions for their own use. It says nothing about sales by such institutions. *Abbott Labs*, however, implicitly decided that whether an item purchased at a discriminatorily low

Appellants ask us to adopt the categorical rules set forth in *Abbott Labs* wholesale and apply them to this case. This suggestion, however, ignores the manner in which these rules were originally derived and would, if adopted, violate the spirit, if not the letter, of the Supreme Court's decision. In *Abbott Labs*, the Court generated its categorical rules by first determining the basic institutional function of a non-profit, fee-for-service hospital and then deciding which sales fit within this institutional function and which did not. Thus, to follow the true mandate of *Abbott Labs* we should not simply adopt the categorical rules set forth in that decision, but should instead determine the basic institutional function of the Kaiser-Permanente Medical Care Program and then decide which sales are in keeping with this function.

Health maintenance organizations (HMO's), such as Kaiser-Permanente, are designed to provide a complete panoply of health care to their members. *See* S. Rep. No. 129, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S. Code Cong. & Ad. News 3033, 3040. *See generally II Report of the National Advisory Commission on Health Manpower* (1967). Whereas fee-for-service hospitals provide health care on a temporary and usually remedial basis to their patients, HMO's provide continuing and often preventive health care for their members. *See* 42 U.S.C. § 300e(b)(1)-(2) (describing a HMO's continuing obligations to its members). Given this extraordinarily broad institutional function, any sale of drugs by an HMO to one of its members falls within the basic function of the HMO. Consequently, we must conclude that drugs purchased by an HMO, such as Kaiser-Permanente, for resale to its members are purchased for the HMO's

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price was purchased for the institution's own use depends on whether and how the item was resold. *See generally* 3 E. Kinter & J. Bauer, *Federal Antitrust Law* § 25.9 (1983).

"own use" within the meaning of the Nonprofit Institutions Act and thus qualify for protection under the Act.[7]

We believe that this result is in keeping with the intent of the 75th Congress which drafted the Nonprofit Institutions Act. Although the exact intent of Congress is less than crystal clear from a reading of the legislative history, *see* Rosoff & Dunfee, A "Fix" for the Retail Pharmacy: The Supreme Court Redefines Application of the Robinson-Patman Act to Drug Sales by Nonprofit Hospitals, 13 Cal. W. L. Rev. 195, 203 n.35 (1977), at least one Justice has concluded that the Act was passed because "Congress was primarily interested in directly aiding nonprofit institutions by lowering their operating expenses, but not interested in indirectly aiding such institutions by providing them with the means of raising additional money." *Abbott Labs*, 425 U.S. at 23 (Marshall, J., concurring). If that principle is applied to this case,

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[7] HMO's, such as the Kaiser-Permanente, can therefore engage in some sales that would not be allowed if we applied the ten categorical rules formulated in *Abbott Labs* to this case.

For instance, in *Abbott Labs*, the Court held that fee-for-service hospitals cannot purchase drugs at discriminatorily low prices if those drugs are sold to refill a prescription, even if the original prescription was filled as part of an exempt sale. 425 U.S. at 15-16. It appears that the Court declined to exempt prescription refills because the basic institutional function of a fee-for-service hospital is to provide temporary medical care for its patients. Refilling prescriptions goes beyond that basic institutional function because it extends the relationship between the fee-for-service hospital and the patient into the indefinite future. *Id.* at 16 (A prescription is not for the hospital's " 'own use' forever just because it originated under hospital auspices. We conclude that the statute's limitation has been exceeded when the connection with the hospital has become as attenuated as it is at the refill stage.").

As we explained in text, however, the relationship between an HMO and its members is ongoing, not temporary. The relationship thus does not attenuate simply because the member stepped out the door of an HMO hospital some time ago. The HMO is consequently acting within its basic institutional function when it refills the prescription of a health plan member.

it supports a finding that all drugs purchased by an HMO for resale to its members fall within the Nonprofit Institutions Act. There can be no question that allowing HMO's to purchase drugs that are resold to members at lower prices directly helps the HMO by lowering the operating expense it must incur to provide this aspect of health care to its membership.

We also believe that a finding that drugs purchased by an HMO for resale to its members qualify for protection under the Nonprofit Institutions Act is in keeping with national health care policy. Under *Abbott Labs*, fee-for-service hospitals are exempted from the Robinson-Patman Act when they provide medicine to their patients. If we held that HMO's, such as Kaiser-Permanente, do not qualify for a similar exemption when they provide medicine for their members, fee-for-service hospitals would enjoy a market advandtage over HMO's. Congress passed the Health Maintenance Organization Act in 1976, however, to ensure that consumers have a free choice among various methods of obtaining medical care because Congress believed that this was the best way to lower the medical costs that consumers must bear. S. Rep. No. 129, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S. Code Cong. & Ad. News 3033, 3039-40. Accordingly, we decline to interpret the somewhat open-ended language of the Nonprofit Institutions Act in a way which would impinge upon the free choice of consumers of medical goods and services.

Our conclusion that drugs purchased by HMO's for resale to members are purchased for the HMO's "own use" and thus qualify for protection under the Nonprofit Institutions Act does not dispose of appellants' Robinson-Patman Act claim, however. Appellees make some sales to walk-in customers who are not members of a Kaiser-Permanente HP. Under our analysis, those sales are not protected by the Nonprofit Institutions Act. Indeed, appellees concede that these sales are not for the HP's "own

use" and thus are not covered by the Nonprofit Institutions Act. Nevertheless, appellees argue that these sales should not be subject to the strictures of the Robinson-Patman Act because the sales are so minor as to be a de minimis violation of the Act. The district court agreed with the appellees, citing to the fact that appellees' sales of drugs to non-members constituted less than one percent of appellees' total sales of drugs.

We do not believe, however, that a court can determine whether or not certain sales are de minimis solely by reference to the percentage of an organization's total sales they constitute. The term de minimis generally refers to the effect of a violation, not to the proportion of a party's conduct which violates the law as compared to that which does not. One percent of appellees' total sales might amount to a substantial dollar volume with a dramatic effect on the ability of the relatively small retail drug stores to compete. We therefore remand this case to the district court for an evaluation of the impact of appellees' non-exempt sales on competition in the retail drug market.[8]

III. THE ATTEMPTED MONOPOLIZATION CLAIM

To establish a claim for attempted monopolization, a plaintiff must show that the defendant had a specific intent to monopolize the market, that there was a dangerous probability that the attempt might succeed, and that the defendant committed acts designed to achieve the illegal

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[8] Appellees contend that they would cease sales to nonmembers if they were certain that doing so would not subject them to liability for violation of state licensing law, state tax law, or state rules of tort liability. This record, however, is not nearly sufficient to demonstrate that the operation of these state laws immunizes appellees' conduct under the standard for antitrust immunity set forth in *California Retail Liquor Dealer's Ass'n v. Midcal Aluminum*, 445 U.S. 97 (1980). Nor have appellees made clear why closing the pharmacies to non-members would violate federal tax law, as they assert in their brief.

objective of creating a monopoly. *William Inglis & Sons Baking Co. v. ITT Continental Baking Co.*, 668 F.2d 1014, 1027 (9th Cir. 1981), *cert. denied*, 103 S.Ct. 57, 58 (1982).

We find that appellants failed to raise a genuine issue of material fact on the question whether the appellees engaged in acts designed to monopolize the market for retail drugs. The only evidence offered by appellants in opposing appellees' motion for summary judgment shows merely that the appellees drove hard bargains with pharmaceutical companies and obtained the best prices possible.[9] Appellants offered no evidence of predatory intent, such as proof that appellees coerced pharmaceutical companies into selling drugs to them below cost, or that appellees, in turn, sold drugs to their members below the cost of acquiring the drugs. Nor did appellants present any evidence that appellees coerced pharmaceutical companies into harming appellants. Accordingly, summary judgment was properly granted on this claim.

IV. THE TIE-IN CLAIM

To establish a tying claim, a plaintiff must first demontrate that the defendant is selling two distinct products as a package. He must then show that the defendant has sufficient power in the market for one product (the tying product) to encourage consumers to buy the other product (the tied product) when they might not ordinarily do so. *See Portland Retail Druggists Ass'n v. Kaiser Foundation Health Plan*, 662 F.2d 641, 648 (9th Cir. 1981).

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[9] To bolster their attempted monopolization claim, appellants filled their opening brief with references to an affidavit by Howard Steinbach. The district court ruled, however, that the information in that affidavit was not admissible because the affidavit contained nothing but conclusory statements and hearsay. We agree with the district court's ruling on this point and consequently do not consider the Steinbach affidavit.

Appellants claim that appellees have made three such tying arrangements. All of these arrangements involve the drug plan that appellees sell to members. The first alleged tying arrangement is between the drug plan (the tied product) and the basic health plan (the tying product). The second is the converse arrangement between the health plan (the tied product) and the drug plan (the tying product). The third is between the drugs sold at appellee's facilities (the tied product) and the drug plan (the tying product).

None of these contentions is meritorious. The first alleged arrangement is not an illegal tie-in because appellees do not require that one purchase the drug plan to obtain the health plan. Appellants have no standing to attack the second alleged arrangement because they are not competitors in the market for the tied product, health plans. *See Aurora Enterprise, Inc. v. National Broadcasting Co., Inc.*, 688 F.2d 689 (9th Cir. 1982) (only consumers and competitors in the market for the tied product have standing to bring suit). Nor can appellants succeed on their third contention because we have already rejected the theory that a drug plan and the drugs provided under that plan are separate commodities for purposes of the Clayton Act. *Klamath Lake Pharmaceutical Assn. v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1288-90 (9th Cir. 1983), *cert. denied*, 104 S.Ct. 88 (1984).

C. CONCLUSION

In sum, we affirm the district court's grant of summary judgment with respect to the claim of attempted monopolization and the tie-in claim. We also affirm the district court's conclusion that drug purchases made by appellees for resale to their members are exempt from the Robinson-Patman Act under the exception created by the Nonprofit Institutions Act. We reverse, however, the district court's determination that appellees' sales of

drugs to non-members constituted a de minimis violation of the Robinson-Patman Act, and we remand to the district court for reconsideration of this question.

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.[10]

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[10] Appellants also made an emergency motion to strike portions of appellees' Excerpt of Record. We took this motion under submission with the rest of the case.

The portion of the Excerpt of Record which appellants wish to strike served as an important basis for the district court's factual findings in this case. It was thus proper for appellees to include it in their Excerpt of Record. Consequently, appellants' motion is denied.

APPENDIX B

UNITED STATES COURT OF APPEALS
NINTH CIRCUIT

Nos. 78-2465, 78-2466

PORTLAND RETAIL DRUGGISTS ASSOCIATION, *etc.*,
Plaintiff-Appellant,

v.

KAISER FOUNDATION HEALTH PLAN, *et al.*,
Defendants-Appellees.

Argued Dec. 3, 1980

Submitted Dec. 17, 1980

Decided Nov. 30, 1981

Appeal from the United States District Court
for the Central District of California

Before GIBSON,* SNEED and POOLE, *Circuit Judges.*

POOLE, Circuit Judge:

Several retail pharmacies, and a non-profit trade association to which some of them belong, appeal the orders of the district court disposing of all of their claims brought in two consolidated antitrust actions. We vacate the entry of judgment and remand for further proceedings.

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* Hon. Floyd R. Gibson, Senior United States Circuit Judge, for the Eighth Circuit, sitting by designation.

I

This litigation began as two separate suits, one filed in the Northern and the other in the Central District of California in January 1977. Each complaint is substantially identical and charges appellees with violations of three distinct antitrust provisions: (1) Section 2(f) of the Robinson-Patman Anti-Price Discrimination Act, 15 U.S.C. § 13(f), by knowingly inducing or receiving pharmaceutical suppliers; (2) Section 2 of the Sherman Act, 15 U.S.C. § 2, by attempting to monopolize the retail drug market; (3) Section 1 of the Sherman Act, by unlawfully tying health products and services for sale. Class allegations were pleaded.

The various appellees together make up "health maintenance organizations," operating under the Kaiser-Permanente Medical Care Program (Kaiser). A health maintenance organization, like the typical health insurer, in an actuarial sense spreads the financial cost of health services by charging each of its members annual dues. Unlike typical insurance, the organization itself provides health services. Among the services offered by Kaiser is a drug benefit plan which permits members to obtain pharmaceutical products from Kaiser-operated pharmacies on favorable terms. Existence of the plans, and their perceived effect on the retail pharmacy business of appellants, led to the two lawsuits.

On April 11, 1977, the Judicial Panel on Multidistrict Litigation consolidated these cases in the Central District of California where they were assigned to Judge Hill. On May 23, 1977, the court convened a status conference aimed at lending some procedural order to this complex litigation. That conference produced a pretrial order, filed by the court on July 26, 1977.

Initially, the pretrial order classified these cases as complex and directed them to be conducted pursuant to the *Manual for Complex Litigation.* Memorialized in the

order was Kaiser's intention to file with the court Fed.R. Civ.P. Rule 12(b) motions to dismiss on several grounds. Although these motions were not described in the order, the primary allegations asserted as grounds for dismissal (and those relevant on this appeal) were that: (1) Kaiser engages in the business of insurance and therefore enjoys antitrust immunity by virtue of the McCarran-Ferguson Act, 15 U.S.C. § 12012(b);[1] (2) Appellants' Robinson-Patman cause of action failed to state a claim because Kaiser is exempt from liability pursuant to the Robinson-Patman Price Discrimination Act, 15 U.S.C.§ 13c; (3) Appellants' attempt to monopolize cause of action failed to state a claim; (4) Appellants' tying cause of action failed to state a claim.[2]

The pretrial order indicated that the district court would first consider the 12(b) motions to dismiss at a hearing set for January 23, 1978. Assuming appellants' complaint should withstand these tests of is sufficiency, a hearing was then scheduled a week later on appellants' motion to certify a class which was to be shortly filed.

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[1] Section 2 of the McCarran-Ferguson Act, 15 U.S.C. § 1012, reads:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

[2] These characterizations of the motions are essentially Kaiser's.

The remainder of the order set out a briefing schedule. On August 1, 1977, Kaiser was to file the "Rule 12(b) motion and supporting papers based on the McCarran-Ferguson Act exemption and shall file [the] remaining Rule 12(b) motions without supporting papers." On November 1, 1977, Kaiser was to file supporting papers in connection with all the motions other than McCarran-Ferguson which it had noticed on August 1. Limited discovery was permitted by the order "relating to defendant's aforementioned Rule 12(b) motions and plaintiff's motion to certify a class."

As ordered, Kaiser filed its "Notice of Motion . . . to dismiss and to strike under Fed.R.Civ.P. Rule 12." Although styled a Rule 12 motion to dismiss, the final sentence provided: "To the extent matters outside the pleadings are presented to, and not excluded by the Court, the motions shal be treated as ones for summary judgment pursuant to the last sentence of Fed.R.Civ.P. Rule 12(b)."

Accompanying this motion was the "Affidavit of Scott Fleming in suport of defendants' Rule 12(b) motions and alternative motions for summary judgment." That affidavit is a general discussion of the Kaiser program organization and operations, including the drug benefit program. It was submitted pursuant to the discovery order as a supporting paper in connection with the McCarran-Ferguson motion.

The limited discovery authorized in the order proceeded. Appellants propounded interrogatories, took two depositions and obtained production of numerous Kaiser documents. In July, appellants returned to the district court seeking discovery of pricing information from Kaiser. The justification offered for the request was appellants' claim that if Kaiser did not receive significant discounts on drugs purchased, or received discounts only as to certain drugs, the case might be dropped or the

class of plaintiffs narrowed. The request for broadened discovery was denied; for purpose of all pending motions Kaiser conceded that it received price discounts.[3]

On November 1, 1977, Kaiser filed supporting papers in connection with the remaining motions noticed in August (other than McCarran-Ferguson). Although described in the August notice as motions to dismiss (except for the sentence mentioned above which reserved the possibility of conversion to summary judgment motions), the motions were now clearly labelled in the alternative: for dismissal or summary judgment. In addition, a second affidavit of Scott Fleming was filed dealing particularly with factual issues implicated by Kaiser's newly filed supporting papers.

Appellants responded to Kaiser's motions claiming surprise that matters beyond the pleadings were submitted and reiterating their understanding that only 12(b) motions were to be considered by the court. Nonetheless, two affidavits were filed, executed by Stanley Harman. One was tendered in specific response to the McCarran-Ferguson motion and the other related to the price and contract arrangements by which Kaiser acquired drugs from manufacturers.

The case came on for hearing before the district court on January 23 and 24. At the outset, the court announced that it was prepared to consider matters outside the pleadings in ruling on Kaiser's motions and would therefore proceed as though the motions were for summary judgment under Fed.R.Civ.P. 56. Appellants objected but the district court found that, since August, appellants had been fairly apprised that the motions before the court would be treated as for summary judgment, and that the three-month discovery permitted (until November 1) by the pretrial order was reasonable. The

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[3] Other discovery disputes which have marked this litigation need not be discussed in resolving this appeal.

court noted that adequate discovery had been conducted, particularly as to the McCarran-Ferguson defense, and appellants were unable to specify with particularity what additional discovery they needed to undertake.

The district court disposed of this case as follows: First, the court granted, in the alternative, Kaiser's motion to dismiss and entered summary judgment as to each cause of action, concluding that the McCarran-Ferguson Act exempted Kaiser from antitrust liability; Second, the court granted Kaiser's motion for summary judgment as to the Robinson-Patman cause of action (count one), concluding that Kaiser was exempt from liability by virtue of the Robinson-Patman Price Discrimination Act, 15 U.S.C. § 13c; Third, the court granted, in the alternative, Kaiser's motion to dismiss and entered summary judgment as to the claim of attempted monopolization (count two), concluding that appellants had failed to allege or create a material issue of fact revealing predatory conduct on the part of appellees; Finally, the court granted, in the alternative, Kaiser's motion to dismiss and entered summary judgment as to the tying claim (count three), concluding that Kaiser's health benefits amounted to one service and not the two required for a tying offense.

Appellants filed a notice of appeal to this Court and the case is now properly before us for decision. Appellants allege procedural defects in the grant of summary judgment and ask that we order the district court's judgment reversed on the merits.

II

Summary judgment may be properly entered when the record before the court on the motion reveals the absence of any material issue of fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56. Before summary judgment may be entered against a party, that party must be afforded both notice that the

motion is pending and an adequate opportunity to respond. Implicit in the "opportunity to respond" is the requirement that sufficient time be afforded for discovery necessary to develop "facts essential to justify [a party's] opposition" to the motion. Fed.R.Civ.P. 56; *see Program Engineering, Inc. v. Triangle Publications, Inc.*, 634 F.2d 1188, 1193 (9th Cir. 1980); *Lucas v. Bechtel Corp.*, 633 F.2d 757, 759 (9th Cir. 1980); *British Airways Board v. Boeing Co.*, 585 F.2d 946 (9th Cir. 1978).

Appellants contend that they were denied both notice that summary judgment motions would be considered by the district court and an adequate opportunity to develop facts crucial to opposing those motions.

A

Questions of adequate notice of a summary judgment motion typically arise when the district court announces its intention to consider matters outside the pleadings in ruling on what has been noticed by the moving party as a Rule 12(b)(6) motion to dismiss. When the district court looks outside the pleadings in evaluating a noticed Rule 12(b)(6) motion, the motion must be converted and treated as one for summary judgment under Rule 56. *See Lucas v. Bechtel Corp., supra*, 633 F.2d at 759. If the conversion occurs unexpectedly, the non-moving party is left at the disadvantage of being unprepared to respond; hence notice is required. *See, e.g., Costen v. Pauline's Sportswear, Inc.*, 391 F.2d 81, 85 n.5 (9th Cir. 1968). The primary vice of unexpected conversion to summary judgment is that it denies the surprised party sufficient opportunity to discover and bring forward factual matters which may become relevant only in the summary judgment, and not the dismissal, context.

In evaluating the adequacy of notice, this circuit has determined from the record whether the party against whom summary judgment was entered was fairly ap-

prised that the court would look beyond the pleadings and thereby transform the 12(b) motion to dismiss into one for summary judgment. *See, e.g., id.* In this case, the district court found that appellants were apprised that materials outside the pleadings would be before the court "at least" in August when Kaiser filed its notice of motions and its specific papers relating to the McCarran-Ferguson defense.

As to the McCarran-Ferguson motion, we agree that appellants were reasonably notified that matters outside the pleadings were to be considered in connection with the pending Rule 12(b) motion to dismiss; they were on notice that the three month discovery period should be used to met the affidavit submitted in connection with the August 1 McCarran-Ferguson motion.

That three month period was also sufficient to generate or develop facts relevant to the McCarran-Ferguson issue. Appellants conducted extensive discovery relating to this motion and submitted their own affidavit to the court. Denial of more time to conduct discovery relating to this motion was not an abuse of the district court's discretion. *See British Airways Board v. Boeing Corp., supra.*

As to Kaiser's other motions, by the terms of the pretrial order, Kaiser was not required to file supporting papers until November 1, 1977. It was only on that date that the appellants saw the facts Kaiser would rely upon in seeking judgment, as contained in the second affidavit of Scott Fleming and described in the moving papers.

But November 1 was also the date the pretrial order ended discovery. Thus, on the date appellants were fully aware of the character of Kaiser's motions, as they would be argued to the court, and notified in the second Fleming affidavit of many of the facts to be presented, discovery was no longer possible under the court's order.

We think this unusual predicament left appellants at an unfair disadvantage as to all of Kaiser's motions save

that in connection with the McCarran-Ferguson Act. That predicament, coupled with the need for caution in summarily adjudicating complex antitrust cases, *Poller v. Columbia Broadcasting System*, 368 U.S. 464, 473, 82 S.Ct. 486, 491, 7 L.Ed.2d 458 (1962), leads us to conclude that the entry of summary judgment was premature and that the case should be returned to the trial court with additional fact-seeking time.

We emphasize in reaching this conclusion that we express no view on the scope of discovery which should be afforded appellants on remand.[4] The court may exercise its sound discretion to limit the parties to investigation of factual issues critical to such motions for summary judgment which may be before the court or may hereafter be filed. We hold only that the defending party's opportunity to discovery should not be foreclosed by order of the court before the moving party has presented critical factual materials on which he intends to rely and against which a defense is to be mounted.

Because the procedure used to enter summary judgment on all but the McCarran-Ferguson motions did not provide an adequate opportunity for discovery, we vacate the entry of summary judgment as to all issues before the district court save that of the applicability of the McCarran-Ferguson antitrust exemption.

III

Premature entry of summary judgment does not taint certain of the district court's rulings dismissing appellants' attempt to monopolize and tying counts on the pleadings pursuant to Rule 12(b)(6) and finding Kaiser exempt from antitrust liability under the McCarran-Ferguson Act. We turn to these issues.

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[4] Appellants have submitted to us factual materials which were not offered in the district court. We have not considered these materials because our function is to review the record before the district court. It is not appropriate for counsel to try to build such a record in this court.

A

Since the district court decision, the Supreme Court has decided *Group Life Health & Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979). In that case, the insured entered into a pharmacy agreement with Blue Shield insurance company which allowed him to purchase drugs from Blue Shield approved pharmacies for $2.00; Blue Shield would make a further payment to the pharmacist. To become an "approved" pharmacy, the druggist had to agree that Blue Shield's contribution would be the direct cost of the drug to the drugstore. When these agreements between Blue Shield and approved pharmacies were challenged as violative of the antitrust laws, the McCarran-Ferguson defense was invoked. The Court agreed with the Fifth Circuit that the agreements between Blue Shield and the participating pharmacies were not the "business of insurance" so as to be exempt from most antitrust liability under McCarran-Ferguson.

As to appellants' first two causes of action, *Royal Drug* requires the conclusion that the McCarran-Ferguson Act does not apply. In these counts, appellants are challenging the contractual arrangements and conditions by which Kaiser acquires drugs from manufacturers, wholesalers and distributors. Conceptually, this is identical to the situation in *Royal Drug*. All that differs is that Kaiser distributes the drugs itself. But that makes no difference because the antitrust violation alleged stems from the arrangement by which Kaiser acquires the drugs.

As for the tying cause of action, appellants are challenging conditions Kaiser may or may not place on its relationships with members. Whether those conditions sufficiently partake of the "indispensable characteristic of insurance"—"spreading of risk," recognized in *Royal Drug* as essential for application of the McCarran-Ferguson defense, is a question which we cannot presently

decide. *Group Life & Health Ins. Co. v. Royal Drug Co., supra*, 440 U.S. at 212, 99 S.Ct. at 1073. When this case was argued in the district court an expansive perception of the "business of insurance" requirement prevailed in a majority of the circuit courts of appeals. *See, e.g., Proctor v. State Farm Mut. Auto. Ins. Co.*, 561 F.2d 262 (D.C. Cir. 1977). Kaiser conducted discovery and prepared its case based on that broad perception of the requirement and accordingly did not prepare itself for the subtleties of the defense now revealed by *Royal Drug. See* L. A. Sullivan, *Recent Antitrust Developments: Defining the Scope of Exceptions, Expanding Coverage, and Refining the Rule of Reason*, 27 U.C.L.A.L.Rev. 265, 288 (1979). Because the issue might well implicate factual matters which Kaiser did not have an opportunity [to] prepare, *id.*, we vacate entry of judgment on the third cause of action based on the McCarran-Ferguson defense and remand for consideration of this issue in light of *Royal Drug*.

B

The district court alternatively dismissed appellants' Sherman causes of action (two and three of the complaint) for failure to state claims. The court found that no amendments could be made to state claims.

Reviewing dismissals, we are limited to an examination of the complaint; must accept all allegations of fact as true; and resolve all doubts in favor of the pleader. *Ernest W. Hahn, Inc. v. Codding*, 615 F.2d 830, 834 (9th Cir. 1980). Mindful of the reluctance of federal courts to dismiss a case such as this on the pleadings, *Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738, 746, 96 S.Ct. 1848, 1853, 48 L.Ed.2d 338 (1976), we proceed with the required review.

1.

Appellants' complaint alleges that Kaiser has attempted to monopolize the business of drug sales by coercing drug

companies, wholesalers and distributors to grant to Kaiser prices lower than those otherwise available to retail pharmacies. It is further alleged that Kaiser has resold drugs so obtained at prices less than those that could be charged by appellants, to the injury of appellants.

A section 2 attempt to monopolize claim contains three elements: (1) specific intent to control prices or destroy competition in some part of commerce; (2) predatory or anticompetitive conduct directed to accomplishing the unlawful purpose; and (3) a dangerous probability of success. *William Inglis & Sons Baking Co. v. ITT Continental Baking, Co.* 652 F.2d 917, at 931 (9th Cir. 1981); *California Computer Products, Inc. v. IBM Corp.*, 613 F.2d 727, 736 (9th Cir. 1979). While these elements are discrete, they are often interdependent. *Inglis, supra*, at 931.

The district court concluded that appellants had failed to allege predatory conduct: a required element of a section 2 claim. Fairly read, the complaint does allege coercive activities by defendants to obtain reduced prices and thereby attempt to gain a monopoly position in the retail drug market. Although the evidence of predation which appellants expect (or hope) to prove is not detailed, antitrust pleadings need not contain great factual specificity. *See, e.g., Hunt-Wesson Foods, Inc. v. Ragu Foods, Inc.*, 627 F.2d 919, 924 (9th Cir. 1980).

We find the allegation of coercive attempts to obtain specifically-reduced prices sufficient for this complaint to state a possible section 2 claim. It may be that the coercion appellants will prove is of a kind: (1) "forming the basis for a substantial claim of restraint of trade, or (2) conduct that is clearly threatening to competition or clearly exclusionary." *Inglis, supra*, at 933 n. 11. In some cases, "clearly exclusionary conduct" itself may provide the basis for a section 2 claim because it may generate inferences sufficient to satisfy the other elements of the attempted monopolization offense. *See id.*;

Hunt-Wesson Foods, Inc. v. Ragu Foods, Inc., supra, 627 F.2d at 925-26; *Gough v. Rossmoore Corp.*, 585 F.2d 381, 390 (9th Cir. 1978). At this pleading stage, it is not possible to test the conduct of Kaiser and determine whether such a section 2 case may have been made. It has been alleged and that is all that concerns us at this time.

2.

A tying agreement prohibited by section 1 of the Sherman Act exists if three criteria are present: (1) Two distinct products or services are in fact tied such that the products are offered as a single package; (2) The defendant has sufficient economic power in the tying market to impose restrictions in the tied product market; (3) The amount of commerce in the tied product is not insubstantial. *Fortner Enterprises, Inc. v. United States Steel Corp.*, 394 U.S. 495, 499, 89 S.Ct. 1252, 1256, 22 L.Ed.2d 495 (1969); *Moore v. Jas. H. Matthews & Co.*, 550 F.2d 1207, 1212 (9th Cir. 1977). Kaiser contends that no tie exists that appellants may challenge. The complainants allege that Kaiser tied

> the receipt or distribution of over-the-counter and prescription drugs to the purchase of health services from defendants, thus compelling persons receiving health services from or through defendant to obtain drugs from defendants or forego the benefits for which they or their employees had paid defendants.

There has been a good deal of confusion in identifying the tied products or services. For purposes of our review of the pleadings, the question is whether appellants could prove any set of facts under the pleadings which would state a section 1 tying claim. We think that this pleading may be fairly read to allege that Kaiser requires customers to buy its drug plan in order to obtain the health plan. That is a classic tie about which, if proved, appellants could complain and we therefore can-

not agree that, under no set of facts could they prove illegal tying.

IV

The judgment of the district court dismissing the second and third causes of action on the pleadings is reversed. Judgment for Kaiser on the first two causes of action, entered based on the McCarran-Ferguson defense is reversed. As to all other bases for the district court's decision, we vacate the judgment and remand this case for further proceedings consistent with this opinion.

APPENDIX C

CASES ADJUDGED

IN THE SUPREME COURT OF THE UNITED STATES

AT

OCTOBER TERM, 1975

No. 74-1274

Argued December 16, 1975—Decided March 24, 1976

ABBOTT LABORATORIES, *et al.*

v.

PORTLAND RETAIL DRUGGISTS ASSN., INC.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

James H. Clarke argued the cause for petitioners. With him on the briefs were *William B. Crow, Garry P. McMurry, R. R. Bullivant, Walter J. Cosgrave, Jack L. Kennedy, Thomas M. Triplett, Robert R. Carney,* and *Barnes H. Ellis.*

Roger Tilbury argued the cause for respondent. With him on the briefs was *Henry Kane.**

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* *Richard J. Wertheimer* and *Cary H. Sherman* filed a brief for the American Hospital Assn. as *amicus curiae* urging reversal.

Briefs of *amici curiae* urging affirmance were filed by *H. R. Burnham* and *James Allen Main* for the Alabama Pharmaceutical Assn. et al.; and by *Arthur B. Hanson, W. Frank Stickle, Jr.,* and *Sidney Waller* for the American Pharmaceutical Assn. et al.

MR. JUSTICE BLACKMUN delivered the opinion of the Court.

The Robinson-Patman Price Discrimination Act (Robinson-Patman), adopted in 1936, 49 Stat. 1526, amending § 2 of the Clayton Act, 38 Stat. 730, in general makes it unlawful for one engaged in commerce to discriminate in price between different purchasers of like commodities where, among other things, "the effect of such discrimination may be substantially to lessen competition." 15 U.S.C. § 13(a). The Nonprofit Institutions Act, adopted only two years later, in 1938, c. 283, 52 Stat. 446, exempts from the application of Robinson-Patman "purchases of their supplies for their own use by schools . . . hospitals, and charitable institutions not operated for profit." 15 U.S.C. § 13c.[1]

This case concerns nonprofit hospitals' purchases of products at favored prices from pharmaceutical companies. The issue is the proper construction of the phrase "purchases of their supplies for their own use," as it appears in the Nonprofit Institutions Act, and the consequent extent the hospitals' purchases are exempt from the proscription of Robinson-Patman.

I

Petitioners are 12 manufacturers of pharmaceutical products. Respondent, an Oregon nonprofit corporation and assignee of more than 60 commercial pharmacies doing business in the metropolitan Portland, Ore., area, instituted this action against petitioners in the United States District Court for the District of Oregon for violations of the federal antitrust laws. Treble damages and injunctive relief were sought.

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[1] "Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, charities, hospitals, and charitable institutions not operated for profit."

The amended complaint asserted five causes of action. Only one of the five (the second) is presently before us.[2] In this claim the respondent alleged that in selling pharmaceutical products petitioners discriminated between nonprofit hospitals, on the one hand, and commercial pharmacies (regular drugstores), including respondent's assignors, on the other. As an affirmative defense, petitioners pleaded that their sales of pharmaceutical products to nonprofit hospitals were exempt from Robinson-Patman under the Nonprofit Institutions Act.

The parties engaged in discovery as to the nonprofit status and drug-dispensing practices of 14 designated metropolitan Portland area institutions that operate as nonprofit hospitals. Affidavits were obtained and filed. Petitioners, as defendants, pursuant to Fed. Rule Civ. Proc. 56(b), then moved for summary judgment on the amended complaint's second cause of action. App. 68.

The District Court, by an opinion delivered orally, ruled that all the designated institutions were nonprofit hospitals, and that their purchases of pharmaceutical products from petitioners were purchases of supplies "for their own use," within the language of 15 U.S.C. § 13c, and thus were exempt from the restrictions of Robinson-Patman. The court concluded, accordingly, that there was no issue as to any material fact with respect to the hospitals' nonprofit status or their use of the pharmaceutical products they purchased, and granted summary judgment in favor of the petitioners on the respondent's second cause of action. App. 278-288, 290-292.

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[2] Causes of action based on discrimination in sales to city, county, and state governments, and to the Federal Government (the third and fourth causes of action asserted in the amended complaint, Record 61-62) were dismissed for failure to state a claim. App. 292. A cause of action based on discrimination in sales to proprietary hospitals and commercial entities, and one that the alleged discriminations were the product of a conspiracy (the amended complaint's first and fifth causes of action, Record 52-61, 62-63), remain pending.

The District Court, *id.*, at 292, certified its judgment under 28 U.S.C. § 1292(b), and the United States Court of Appeals for the Ninth Circuit permitted the interlocutory appeal to be taken. The Court of Appeals, while rejecting respondent's contentions that the designated hospitals did not qualify for exemption under § 13c,[3] nevertheless vacated the District Court's judgment and remanded the case for further proceedings. 510 F. 2d 486 (1974).

Because of the importance of the issue in the context of the modern nonprofit hospital, with its expanding service to the community, as compared with hospital operations of some years ago, and because of the obvious need for a definitive construction of language in the Nonprofit Institutions Act,[4] we granted certiorari. 422 U.S. 1040 (1975).

II

The pertinent facts are not really in dispute. The petitioners, admittedly, sell their pharmaceutical products to the designated Portland hospitals at prices less than those that govern petitioners' sales of like products to the respondent's assignors who are commercial pharmacists in Portland. The respective hospitals in turn dispense the pharmaceutical products they have so purchased from the petitioners. The application of Robin-

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[3] The sole exception was Bess Kaiser Hospital. As to this institution, the Court of Appeals concluded that certain factors "appear to present disputed issues of fact," and that the "proper legal standard" for determining whether that hospital was " 'not operated for profit' " could not be developed "on the limited record" before the court. The issue, therefore, was to be resolved on remand. 510 F. 2d 486, 488 (1974). No review of this aspect of the Court of Appeals' judgment has been sought, and that detail is not before us. Neither are we confronted here with an issue as to the non-profit status, within § 13c, of the other 13 hospitals.

[4] See the same Court of Appeals' decision in *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F. 2d 212, cert. denied, 389 U.S. 898 (1967).

son-Patman to this situation is conceded except to the extent the exemption provision of the Nonprofit Institutions Act applies. The controversy, thus, comes into clear focus.

Each of the designated hospitals has a pharmacy. It is a separate department of the hospital. Its operation produces revenue in excess of costs. The net accrues to the hospital's benefit, is utilized for the institution's general purposes, and thus supports other activities of the hospital.

The District Court, App. 283-285, and the Court of Appeals, 510 F. 2d, at 489, each perceived various categories of dispensations by the hospital pharmacies of the pharmaceutical products purchased from petitioners. But the District Court, in sustaining petitioners' motion for summary judgment, observed that "the vast majority" of the products purchased (85% to 95%), namely, those for the bed patient and for the patient receiving treatment in the hospitals' emergency facilities, were "clearly" for the hopsitals' use, within the meaning of the Nonprofit Institutions Act, App. 283; that "out-patient treatment," whether "initial or repeated," was not outside that Act merely because there has been a "change in the distribution of health care" whereby the percentage of out-patient treatment increased since the statute was passed in 1938, *id.*, at 284; that "take-home drugs" were within the "clear meaning" of the statute, *ibid.*; that drugs furnished to employees, staff physicians, and other members of the staff, while presenting "some mild degree of question," nevertheless were "for the use of the hospital," *id.*, at 285; and that the situation with respect to walk-in patients was insufficient in amount to "justify withdrawing" the statute's exemption, *ibid.*

The Court of Appeals agreed that the inpatient and emergency facility situations "cover by far the greater part of hospital distribution," and that "such dispensing

of drugs in the course of treatment in the hospital is the hospitals' [*sic*] own use." 510 F. 2d, at 439. The court recited petitioners' asserted justifications for the other type of sales "as proper hospital functions": the need of the departing inpatient for take-home drugs; the continuation at home of the patient's treatment begun earlier in the hospital; the sales to employees as being pursuant to collective-bargaining agreements; the sales to students as being aspects of the hospital's educational programs; the sales to physicians as being perquisites of hospital staff membership; the limitation of walk-in sales to instances where, at the time, the needed drugs could not be obtained elsewhere; the hospital's position "as a center for the provision of a full range of health services"; and "a decent regard for the needs of the community." *Ibid.*

But, conceding that "distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function," the Court of Appeals concluded that this was not necessarily "the hospitals' 'own use.'" Instead, said the court, hospital use under § 13c was limited to cases where the hospital can be said to be the consumer, that is, to those cases where the dispensation of drugs were to inpatients and emergency facility patients. The concept could not apply "to cases of resale by the hospital to a private consumer." Accordingly, as to such sales, the hospital may not acquire the pharmaceutical products "at an acquisition price that discriminates against local retail druggists." *Ibid.*

III

We, too, find it convenient to view the hospitals' sales and dispensations of the pharmaceutical products purchased from petitioners as falling into several categories.[5] We divide them as follows:

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[5] The record does not show that each of the designated hospitals made dispensations in each category. It does indicate that dis-

1. To the inpatient for use in his treatment at the hospital. For present purposes, we define an inpatient as one admitted to the hospital for at least overnight bed occupancy.[6]

2. To the patient admitted to the hospital's emergency facility for use in the patient's treatment there. A patient in this category may or may not become an inpatient, as defined in the preceding paragraph.

3. To the outpatient for personal use on the hospital premises. For present purposes, we define an outpatient as one (other than an inpatient or a patient admitted to the emergency facility) who receives treatment or consultation on the premises.

4. To the inpatient, or to the emergency facility patient, upon his discharge and for his personal use away from the premises.

5. To the outpatient for personal use away from the premises.

6. To the former patient, by way of a renewal of a prescription given when he was an inpatient, an emergency facility patient, or an outpatient.

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pensations in each category were made by the hospitals considered as a group. Some hospitals refused to make certain types of dispensations. It would serve no useful purpose for us to describe the extent to which each individual hospital made dispensations in the several categories.

[6] A patient admitted for overnight bed occupancy, in the estimation of the several affiants whose affidavits appear in the record, clearly is an "inpatient." Some would carry the description further to include a patient admitted only for day surgery, or one who remains 12 hours or more, irrespective of overnight bed occupancy. In view of our disposition of the case, these distinctions are of no consequence here.

7. To the hospital's employee or student for personal use or for the use of his dependent.[7]

8. To the physician who is a member of the hospital's staff, but who is not its employee, for personal use or for the use of his dependent.

9. To the physician, who is a member of the hospital's staff, for dispensation in the course of the physician's private practice away from the hospital.

10. To the walk-in customer who is not a patient of the hospital.[8]

This division into categories reveals, of course, that we are concerned with linedrawing. The demarcation is somewhat simplified, on this record, by a concession on the part of the respondent. The respondent agrees with the Court of Appeals that the dispensing of drugs " 'in the course of treatment in the hospital is the hospitals' [*sic*] own use,' " regardless of whether the patient is technically described as an outpatient or as an inpatient. It does not matter, the respondent says, "whether the patient is occupying a bed or not"; thus, a "day surgery patient receiving medication while being treated in the hospital would be covered [that is, the sale to him would be exempt] whether in bed or not, as would one receiving a shot or pill while standing upright or otherwise in the outpatient clinic." Brief for Respondent 11. See also Tr. of Oral Arg. 29.

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[7] The record seemingly contains no reference to a dispensation to a special duty nurse, chaplain, or similar nonemployee professional, on duty at the hospital. We place any dispensation of this type in the same category as one to the hospital's employee or student.

[8] This division into 10 categories may not be exhaustive. It appears to cover, however, the several types of dispensations indicated by the record.

This concession, then, covers the above-listed categories 1, 2, and 3. We hasten to add, however, that if the respondent had made no concession as to these three categories, we would have reached the same result, for it seems to us to be very clear that a hospital's purchase of pharmaceutical products that are dispensed to and consumed by a patient on the hospital premises, whether that patient is bedded, or is seen in the emergency facility, or is only an outpatient, is a purchase of supplies for the hospital's "own use," within § 13c. In our view, as the respondent's concession indicates, this is so clear that it needs no further explication.

Before we turn to the remaining categories, we should state that we recognize, as the parties do, that the concept of the nonprofit hospital and its appropriate and necessary activity has vastly changed and developed since the enactment of the Nonprofit Institutions Act in 1938. The intervening decades have seen the hospital assume a larger community character. Some hospitals, indeed, truly have become centers for the "delivery" of health care. The nonprofit hospital no longer is a receiving facility only for the bedridden, the surgical patient, and the critical emergency. It has become a place where the community is readily inclined to turn, and—because of increasing costs, physician specialization, shortage of general practitioners, and other factors—is often compelled to turn, whenever a medical problem of import presents itself. The emergency room has become a facility for all who need it and it no longer is restricted to cases previously authorized by members of the staff. And patients that not long ago required bed care are often now treated on an ambulatory and outpatient basis. See *Eastern Kentucky Welfare Rights Organization* v. *Simon*, 165 U.S. App. D. C. 239, 249, 506 F. 2d 1278, 1288 (1974), cert. granted, 421 U.S. 975 (1975); Brodie & Graber, Institutional Pharmacy Practice in the 1970's, 28 Am. J. Hosp. Pharm. 240, 241 (1971).

IV

It has been said, of course, that the antitrust laws, and Robinson-Patman in particular, are to be construed liberally, and that the exceptions from their application are to be construed strictly. *United States* v. *McKesson & Robbins*, 351 U.S. 305, 316 (1956); *FMC* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973); *Perkins* v. *Standard Oil Co.*, 395 U.S. 642, 646-647 (1969). The Court has recognized, also, that Robinson-Patman "was enacted in 1936 to curb and prohibit all devices by which large buyers gained discriminatory preferences over smaller ones by virtue of their greater purchasing power." *FTC* v. *Broch & Co.*, 363 U.S. 166, 168 (1960); *FTC* v. *Fred Meyer, Inc.*, 390 U.S. 341, 349 (1968). Because the Act is remedial, it is to be construed broadly to effectuate its purposes. See *Tcherepnin* v. *Knight*, 389 U.S. 332, 336 (1967); *Peyton* v. *Rowe*, 391 U.S. 54, 65 (1968). Implied antitrust immunity is not favored. *United States* v. *National Assn. Securities Dealers*, 422 U.S. 694, 719 (1975). "[O]ur cases have repeatedly established that there is a heavy presumption against implicit [antitrust] exemptions." *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 787 (1975); *United States* v. *Philadelphia Nat. Bank*, 374 U.S. 321, 350-351 (1963). And the focus of Robinson-Patman is on competition "at the same functional level." *FTC* v. *Sun Oil Co.*, 371 U.S. 505, 520 (1963).

But the legislative history of the Nonprofit Institutions Act indicates clearly that that Act was concerned with the suspicion that Robinson-Patman, at the time just recently enacted, actually might operate to outlaw price favors that sellers would wish to grant to eleemosynary institutions. S. Rep. No. 1769, 75th Cong., 3d Sess., 1 (1938); H.R. Rep. No. 2161, 75th Cong., 3d Sess., 1 (1938). The parties here seek to utilize this legislative history in opposite ways. The respondent asserts that the statutory assurance of exemption "was never intended

to countenance a mass invasion of the retail drug sale market by hospitals," Brief for Respondent 34, and that what Congress had in mind was "the role traditionally occupied by hospitals," *id.*, at 35. The petitioners assert that the 1938 statute "was written to assist a wide range of nonprofit institutions to operate at the lowest possible cost in the public interest," Brief for Petitioners 17, and that the focus was on the character of the institution, not on the particular features of its program, and not only on those institutions that operated at a loss, *id.*, at 17-18.

We are not fully persuaded by either view. The modern American hospital developed from an institution originally intended for the sick poor. See *Eastern Kentucky Welfare Rights Organization* v. *Simon*, 165 U.S. App. D. C., at 249, 506, F. 2d, at 1288; E. Fisch, D. Freed, & E. Schachter, Charities and Charitable Foundations § 322 (1974); Bromberg, The Charitable Hospital, 20 Cath. U. L. Rev. 237, 238-240 (1970). Language in the bill which became the 1938 Act, that would have exempted only sales to nonprofit institutions "supported in whole or in part by public subscriptions," was deleted, 83 Cong. Rec. 6065 (1938), and the Act's exemption provision was not so restricted and confined. We thus do not relate the exemption to what might be described as the nonprofit hospital's original or "traditional" status. On the other hand, there is nothing in the Act that indicates that its exemption provision is to be applied and expanded automatically to whatever new venture the nonprofit hospital finds attractive in these changing days. The Congress surely did not intend to give the hospital a blank check. Had it so intended, it would not have qualified purchases by nonprofit institutions in the way it did in § 13c. See H.R. Rep. No. 1983, 90th Cong., 2d Sess., 78-79 (1968). We are concerned, after all, with an exemption from an antitrust statute, and the accepted general principles, hereinabove set forth, do have application even in the nonprofit hospital context.

We therefore conclude that the exemption provision of the Nonprofit Institutions Act is a limited one; that just because it is a nonprofit hospital that is purchasing pharmaceutical products does not mean that all its purchases are exempt from Robinson-Patman; that the test is the obvious one inherent in the language of the statute, namely, "purchases of their supplies for their own use"; and that "their own use" is what reasonably may be regarded as use *by the hospital* in the sense that such use is a part of and promotes the hospital's intended institutional operation in the care of persons who are its patients. This implies the limitation and it turns the measure naturally from the purchase to the use, as § 13c requires. In this focus we consider the several categories listed above.

V

1, 2, and 3. As to these three categories, we reiterate our conclusions already enunciated in the light of the concession by the respondent. Dispensation to the bed-occuping inpatient and to the patient at the hospital's emergency facility, in either case for use on the hospital premises, is a part of the institution's basic function, and is dispensation for the hospital's "own use." That it is the patient rather than the hospital that consumes is not determinative, and, indeed, the respondent here does not contend otherwise. A like result follows with respect to dispensation to the hospital's outpatient when that patient uses the pharmaceutical product on the hospital's premises.

4 and 5. The take-home prescription, usually a continuance of, or supplement to, what has been prescriptively administered at the hospital while the recipient was an inpatient, emergency facility patient, or outpatient, takes us, to be sure, one small step beyond and outside the hospital's door. The patient is released from care to continue his treatment and recuperation under something less than the hospital's emergency or routine

intensive, regular, or even, more casual care (if it offers that type), and less than its consultative service at its outpatient facility. The release from the hospital environment into the home is the next step in the chain of treatment on the patient's way to his resumption of normal activity completely free of treatment. The medical supervision and the hospital's participation in it to this point, at least, although approaching an end, are continuous and real, and are distinct parts of the transition from hospital care to home care. We therefore conclude that the genuine take-home prescription, intended, for a limited and reasonable time, as a continuation of, or supplement to, the treatment that was administered at the hospital to the patient who needed, and now continues to need, that treatment, is for the hospital's "own use." We therefore disagree with the Court of Appeals as to categories 4 and 5. We feel that a contrary ruling on our part would unduly and undeservedly emphasize the doorsill of the hospital, and that to draw a line at that threshold would be arbitrary and not consistent with congressional intent. In these instances, the hospital's "own use" of the pharmaceutical products extends realistically and not inappropriately somewhat beyond that threshold.

6. We conclude, however, that the refill for the hospital's former patient is on the other side of the line that divides that which is in the hospital's "own use" from that which is not. Inevitably, in accord with the test above set forth, there comes a point where the dispensation of pharmaceutical products is not for the institution's "own use." That point, we feel, is positioned short of the refill. Continuation of a drug's use for some time after initial prescription at the hospital may well be indicated for the particular patient, but, except for the limited take-home prescription referred to above, it is not the hospital's "own use," and it certainly is not for its "own use" forever just because it originated under hospital auspices. We conclude that the statute's limitation

has been exceeded when the connection with the hospital has become as attenuated as it is at the refill stage.

7. Dispensation to the hospital's employee or to its student for the purchaser's personal use or for the use of his dependent poses a somewhat different problem. A hospital is an organization populated by persons rendering essential services of various kinds. The hospital's employees enable it to function. The hospital pharmacy is but a part of the whole; the employee and his services are other parts. And to the extent the institution has students on the medical and hospital scene—interns, persons in the hospital's nursing, practical nursing, and nurse's aide programs, those in paramedical, chaplaincy, and administrative fields, and the like—the connection with the hospital's purposes and its activities is obvious and institutionally intimate. We conclude, therefore, that dispensation by the pharmacy to the hospital's employee or student, each of whom, literally, is a member of the hospital family, for his own use or for the use of his dependent, enhances the hospital function and qualifies as being in the hospital's "own use," within the meaning of § 13c.[9] But we draw the line between dispensation for the employee's or the student's personal use, or for the use of his dependent, on the one hand, and that for the use of another, even a nondependent family member, on the other.

8 and 9. What we have said in the preceding paragraph applies with equal force to dispensation to a physician member of the staff for his personal use or for the personal use of his dependent. The physician staff member, though not an employee in the technical sense of being full time in the hospital's service and on its payroll, nevertheless is vital to its existence. It is he who supplies the patient and who engages, perhaps directly and at least

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[9] The fact that, with respect to employees, the availability of the hospital pharmacy might be the compelled subject of a collective-bargaining agreement, in our view, cannot be controlling.

to some extent through the staff organization, in the formulation of the hospital's professional and operative policies. His activity at the hospital is in the hospital's use—its very purpose for existence—and dispensation to the physician and his dependent, we think, is for the hospital's "own use," within § 13c.

We again draw the line, however, when the physician's acquisition from the hospital pharmacy is not for his personal use or that of his dependent, or is not for the hospital. To the extent that the physician utilizes his proximity to the hospital pharmacy, and it permits him so to do, for other persons or other uses—even, as this record occasionally intimates, for dispensation in that portion of his private practice unconnected with the hospital—the requirement of the hospital's "own use" is not fulfilled. Here again the relationship is too attenuated for the statutory benefit, and we hold that § 13c definitely is not satisfied.

10. The walk-in prescription buyer for the most part affords little difficulty for us in the context of § 13c. Even though one acknowledges the full weight of the argument that the modern hospital is a different institution from what it was when the Nonprofit Institutions Act was adopted in 1938, and that increasingly it has become a focus of health care in the community, the extension of § 13c to the walk-in customer, who has no present connection with the hospital and its pharmacy other than as a place to have his prescription filled, would make the commercially advantaged hospital pharmacy just another community drug store open to all comers for prescription services and devastatingly positioned with respect to competing commercial pharmacies. This would extend the hospital's "own use" concept beyond that contemplated by Congress in § 13c.

We therefore hold that the walk-in buyer generally is not within the statute's exemption. We recognize, however, that there may be an occasion when the hospital

pharmacy is the only one available in the community to meet a particular emergency situation. The respondent seeks to counter this possibility with a telephone book yellow-page reference to the providing of 24-hour service, and of some emergency or delivery service, by certain metropolitan Portland retail pharmacies. Brief for Respondent 56. That may be. We are content, however, to conclude that the occasional emergency is *de minimis*, in any event, and that its presence solitarily would not trigger litigation of the present kind. So long as the hospital pharmacy holds the emergency situation within bounds, and entertains it only as a humanitarian gesture, we shall not condemn the hospital and its suppliers to a Robinson-Patman violation because of the presence of the occasional walk-in dispensation of that type.[10]

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[10] We referred above, in n. 4, to *Logan Lanes, Inc.* v. *Brunswick Corp.* The parties, in their respective ways, seek to make as much as possible of that decision. *Logan Lanes* was a treble-damages suit centering in the sale by Brunswick, to a Utah State Board, of bowling lanes and related equipment at prices lower than Brunswick charged Logan for similar equipment. The items purchased by the board were installed in a state university's student union building, and, while they were "primarily for the use of students, faculty and staff of the University," were also used by members of the public, 378 F.2d, at 214. The public use during the 20 months following installation, according to affidavits presented by Brunswick, amounted to 2,934 lines bowled out of a total of 128,349. The trial court granted Brunswick's motion for summary judgment. One ground for this ruling was that the purchase was exempt under § 13c. The Ninth Circuit affirmed. It refused to restrict the statute's use of the term "supplies" to consumables and noncapital items and, instead, held that the term embraced anything required to meet the qualified institution's needs. It concluded that the exact amount of public use was immaterial and that, even assuming "the public made substantial use of the University bowling facilities," 378 F. 2d, at 217, the purchases in question were made by the nonprofit university for its own use. The situation presented by *Students Book Co.* v. *Washington Law Book Co.*, 98 U.S. App. D.C. 49, 232 F. 2d 49 (1955), cert. denied, 350 U.S. 988 (1956), also cited by the parties here, was distinguished.

The latter case concerned sales of lawbooks to self-sustaining campus bookstores for resale at a profit. The Court of Appeals

VI

The petitioners suggest that a decision holding some dispensations by the nonprofit hospital not to be exempt establishes an objectionable and unworkable standard for hospitals and their suppliers because it "requires a segregation of drugs or accounting of their use that can be achieved only through the institution of clumsy and expensive dual supply or tracing systems to regulate and account for the use of drugs." Brief for Petitioners 28. They suggest the undesirability of a supplier's "controlling the disposition of merchandise in the hands of a purchaser," citing *United States* v. *Arnold, Schwinn & Co.*, 388 U.S. 365, 379 (1967), and they speak of the supplier's "retroactive exposure to claims." Brief for Petitioners 29.

Petitioners' concern is understandable, but we feel that it is overstated. Looking at the problem from the point of view of the purchasing hospital, two alterna-

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held, 98 U.S. App. D.C., at 50-51, n. 5, 232 F. 2d, at 50-51, n. 5, that these were not sales to universities "for their own use," within the meaning of § 13c. The defendant, however, prevailed on another ground.

We agree with the court in the *Students Book Co.* case that the purchases challenged there were not purchases by a nonprofit institution of the type to which § 13c relates. Those in *Logan Lanes*, in contrast, were. The Ninth Circuit apparently would distinguish *Logan Lanes* from the present case on the ground that "[p]lant equipment acquired for a university's own use cannot be segregated from that acquired for use by others, since the same equipment serves both uses." 510 F. 2d, at 490. It went on to say that the situation "of supplies acquired for consumption . . . is otherwise." *Ibid.* The court regarded the present case as factually similar to *Students Book Co.* As we have just stated, however, we are in accord with the District of Columbia Circuit's characterization of the bookstore purchases as not being transactions with the universities at all, but with the campus bookstores for resale at the latter's profit.

tives, and perhaps more,[11] are presented. The first, and easier, is for the hospital pharmacy *not* to dispense in any way hereinabove held to be outside the exemption of § 13c. The second is for the pharmacy to do exactly what the petitioners deplore, namely to establish a recordkeeping procedure that segregates the nonexempt use from the exempt use. This would be supplemented by the hospital's submission to its supplier of an appropriate accounting followed by the price adjustment that is indicated. This, to be sure, is cumbersome, but it obviously is the price the Congress has exacted for the benefits bestowed by the controlling legislation, and it should be no more cumbersome than the accounting demands that are made on commercial enterprises of all kinds in our complex society of today.

The supplier, on the other hand, properly may expect to be protected from antitrust liability for reasonable and noncollusive reliance upon its hospital customer's certification as to its dispensation of the products it purchases from the supplier. But it is not unreasonable to expect the supplier to assume the burden of obtaining the certification when it seeks to enjoy, with the institutional purchaser, the benefits provided by § 13c. It clearly does this with respect to responsibility for identification of its purchaser under that statute's standard, and little additional burden is imposed if it is required to take the small second step of routinely obtaining a representation from its hospital customer as to the use of the products purchased.

The judgment of the Court of Appeals is vacated, and the case is remanded for further proceedings consistent with this opinion. Costs are allowed to petitioners to the extent of 50%.

It is so ordered.

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[11] Our reference to two alternatives is not meant to be exclusive. Imaginative suppliers and purchasers may well come up with other and better means to alleviate whatever routine recordkeeping details and burdens may exist.

MR. JUSTICE STEVENS took no part in the consideration or decision of this case.

MR. JUSTICE MARSHALL, concurring.

While I join the Court's opinion, I wish to add a word about the applicability of the exemption provided by the Nonprofit Institutions Act. To my mind, the key to the Act is that it exempts from the Robinson-Patman Act not only an itemized list of institutions, but also all "charitable institutions not operated for profit." 15 U.S.C. § 13c. This suggests to me that the named institutions—schools, colleges, universities, public libraries, churches, and hospitals—were not intended to be limited to their traditional activities in qualifying for the exemption, but may expand those activities and still qualify so long as any new activities for which exempted supplies are purchased are charitable and not operated for profit.

I agree with the Court that the exemption is not "to be applied and expanded automatically to whatever new venture the nonprofit hospital finds attractive in these changing days." *Ante*, at 13. But I believe the exemption *is* applicable to any new venture the hospital finds attractive and that is both charitable and not operated for profit. There is no suggestion—nor could one be made—that the activities the Court today finds outside the exemption fall within this category,* so there is no need to address this problem here. But I write to emphasize that I do not read the Court's opinion as foreclosing hospitals—or other exempted institutions—from expanding their charitable activities in highly untraditional ways and still qualifying for the exemption.

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* This case would be much more difficult for me if the hospitals involved did not all make profits on the sale of drugs to outsiders. *Ante*, at 7. If they did not, we would have to determine in each case whether such sales, even if not within the hospital's institutional function, nonetheless constituted a "charitable" venture of their own.

Likewise, I agree with the Court that the proper inquiry in this case is whether each kind of drug sale by the hospital "is a part of and promotes the hospital's intended institutional operation in the care of persons who are its patients." *Ante*, at 14. However, when a nonprofit institution makes sales for profit, as here, analysis is furthered. I suggest, by recognition of the purpose of the "own use" limitation.

Since all charitable institutions are covered by the Act, the purpose quite obviously is not to freeze a particular charitable institution into a particular kind of charity. Rather, as I understand it, the purpose of the limitation is generally to preclude the institution from taking advantage of its antitrust exemption by buying low-cost supplies solely for the purpose of reselling them at a profit. That is, Congress was primarily interested in directly aiding nonprofit institutions by lowering their operating expenses, but not interested in indirectly aiding such institutions by providing them with the means of raising additional money—particularly when such resales of supplies would put the institution in competition with retail businesses not eligible for the exemption. While I do not believe Congress meant to preclude profit-making sales in the course of the institution's charitable activities—and so I agree that the Court's inquiry is the correct one—I suggest that the nexus between particular sales and those activities should be particularly closely scrutinized when a profit is made to assure that the sales are not made primarily for moneymaking purposes. Thus, sales only arguably within the scope of the institution's charitable activities might be exempted when made on a nonprofit basis and not exempted when made for profit. After analysis with this balancing factor in mind, I agree with the lines drawn by the Court and concur in its opinion.

MR. JUSTICE STEWART, with whom MR. JUSTICE BRENNAN joins, dissenting.

It is common ground in this case that the dispensation of pharmaceutical products for consumption by a hospital's patients upon the hospital's premises constitutes the hospital's "own use" of the products within the meaning of 15 U.S.C. § 13c. The controversy concerns the various other "uses" of these products catalogued in the Court's opinion. *Ante*, at 8-10. As to those uses the Court of Appeals expressed its views as follows:

> "We may concede that in these respects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' 'own use.' . . . The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer.
>
> "The hospitals here are (quite properly) accommodating patients, staff and strangers with means whereby they can conveniently purchase for *their* use. The question is not whether the hospitals can continue to provide this useful community service. The question is whether in providing it they may acquire the drugs for such resale at an acquisition price that discriminates against local retail druggists. We hold that they may not." 510 F. 2d 486, 489.

I agree with the Court of Appeals and would affirm its judgment.